

Master Group Application

Group Sales: Tel: 1-888-371-3060 | Fax: 1-415-955-8819



Balance by CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

1. Employer Group Information			
Full Legal Business Name:	How Long in Business:	Type of Business (Be Specific):	Effective Date: (MM/DD/YY) / /
Primary Group Administrator Contact:	Title:	Phone:	Email:
Secondary Group Administrator Contact	Title:	Phone:	Email:
Federal Employer ID #:	State Employer ID #:	Fax:	Send administrative kit to: <input type="checkbox"/> Employer <input type="checkbox"/> Agent/Broker
Business Physical Address, City, State, ZIP (No P.O. Box):			
Billing Contact:	Title:	Phone:	Email:
Billing Address, City, State, ZIP (if different from above):			
Type of Entity: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> S-Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (explain) _____			
2. Employer Group Plan Coverage Selection			
Medical Plans <input type="checkbox"/> Ruby ¹⁰ HMO Platinum <input type="checkbox"/> Ruby ²⁰ HMO Platinum <input type="checkbox"/> Ruby ⁴⁰ HMO Platinum <input type="checkbox"/> Opal ²⁵ HMO Gold <input type="checkbox"/> Opal ⁵⁰ HMO Silver <input type="checkbox"/> Platinum ⁹⁰ HMO <input type="checkbox"/> Gold ⁸⁰ HMO <input type="checkbox"/> Silver ⁷⁰ HMO <input type="checkbox"/> Bronze ⁶⁰ HMO <input type="checkbox"/> Bronze ⁶⁰ HDHP HMO			
Optional Riders (Applies to all Balance Enrollees) <input type="checkbox"/> Adult Vision (VSP) <input type="checkbox"/> Adult Dental (Delta) <input type="checkbox"/> Other _____			
Note(s) (Internal Use Only):			
3. Employer Premium Contribution		4. Employees Will Be Eligible for Benefits Upon	
Employee (min. 50%): \$ / %	Dependent: \$ / %	1 st of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Other _____	
5. Number of Employees (Employer is responsible for collecting refusal of coverage forms)			
Total # of employees:		Total # of eligible employees (30+hrs/week):	
Total # of eligible employees enrolled in Balance:	Total # of employees who waive coverage:	Annual average # of employees:	
6. Current Carrier Information			
Name of your current group medical insurance carrier(s):			
Are you intending to replace your existing group coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes, Termination Date / /			
Current Workers' Compensation Carrier:			Next Renewal Date (MM/DD/YY): / /

